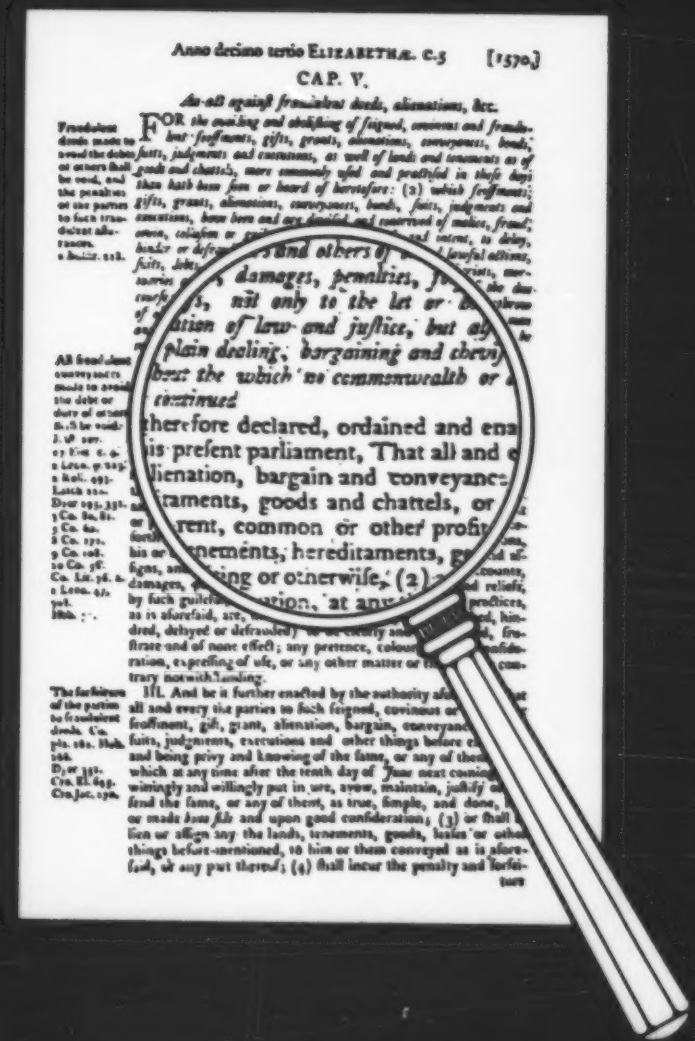
Law Reform
Commission of
Saskatchewan

PROPOSALS FOR AN ADVANCE HEALTH CARE DIRECTIVES ACT

Report to the Minister of Justice

Saskatchewan


Anno decimo tertio ELIZABETHÆ. c. 5 [1570.]

CAP. V.

An act against fraudulent deeds, alienations, &c.

FOR the avoiding and abolishing of feigned, covinous and fraudulent feoffments, gifts, grants, alienations, conveyances, bonds, suits, judgments and executions, as well of lands and tenements as of goods and chattels, more commonly used and practised in these days than hath been seen or heard of heretofore: (2) which feoffments, gifts, grants, alienations, conveyances, bonds, suits, judgments and executions, have been and are devised and contrived of malice, fraud, covin, collusion or guile, to the end, purpose and intent, to delay, hinder or defraud creditors and others of their just and lawful actions, suits, debts, accounts, damages, penalties, forfeitures, hindrances, losses, not only to the let or hindrance of the due course and execution of law and justice, but also to the overthrow of all true plain dealing, bargaining and chevisance between man and man, to the great hurt of the commonwealth or common trade and continued

therefore declared, ordained and enacted by this present parliament, That all and every feoffment, alienation, bargain and conveyance of lands, tenements, hereditaments, goods and chattels, or any of them, by writing or otherwise, (2) and all and every bond, suit, judgment, execution, common or other profit, commodity, charge, lease, rent, office, fee, annuity, liberty, advantage, action, debt, accounts, damages, penalties, forfeitures, reliefs, heriots, mortuaries, and hereditaments, goods and chattels, or any of them, by writing or otherwise, (2) and all and every counsel, privity, bargain, practices, by such guileful means, cause, colour or pretence, or by any such guileful practices, as is aforesaid, are, or shall be had, made, brought, contrived or devised, to the intent, purpose or end to hinder, delayed or defrauded or covinously and fraudulently to be obtained, fraudulent and of none effect; any pretence, colour, feigned consideration, expressing of use, or any other matter or thing to the contrary notwithstanding.

III. And be it further enacted by the authority aforesaid, that all and every the parties to such feigned, covinous or fraudulent feoffment, gift, grant, alienation, bargain, conveyance, bond, suits, judgments, executions and other things before expressed, and being privy and knowing of the same, or any of them, which at any time after the tenth day of June next coming, wittingly and willingly put in use, avow, maintain, justify, or defend the same, or any of them, as true, simple, and done, or made *bona fide* and upon good consideration; (3) or shall alien or assign any the lands, tenements, goods, leases or other things before-mentioned, to him or them conveyed as is aforesaid, or any part thereof; (4) shall incur the penalty and forfeiture

All fraudulent conveyances made to avoid the debt or duty of another shall be void.

The forfeiture of the parties to fraudulent deeds.

92-04080/

PROPOSALS FOR AN ADVANCE HEALTH CARE DIRECTIVES ACT

Law Reform Commission of Saskatchewan

Saskatoon, Saskatchewan

Report to the Minister of Justice

December, 1991

The Law Reform Commission of Saskatchewan was established by **An Act to Establish a Law Reform Commission** proclaimed in November, 1973, and began functioning in February of 1974.

The Commissioners are:

Mr. Dale G. Linn, Q.C., Chairman.

Madam Justice Marjorie A. Gerwing

Mr. Gordon J. Kuski, Q.C.

Mr. Kenneth P.R. Hodges, B.A., LL.B. is Director of Research.

Mr. Michael J.W. Finley, B.A., LL.B. is the Legal Research Officer. The Secretary is Mrs. Kelly Bateman.

* * * * * * * * * * * * * * * * * *

The Law Reform Commission Act.

6. The commission shall take and keep under review all the law of the province, including statute law, common law and judicial decisions, with a view to its systematic development and reform, including the codification, elimination of anomalies, repeal of obsolete and unnecessary enactments, reduction in the number of separate enactments and generally the simplification and modernization of the law....

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Saskatchewan

Law Reform
Commission of
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The Honourable Robert W. Mitchell, Q.C.
Minister of Justice
Province of Saskatchewan
REGINA, Saskatchewan

Dear Mr. Minister:

The "living will" seems to be an idea whose time has come in Saskatchewan. Medical technology now makes it possible to save lives under conditions in which death was inevitable only a few decades ago. But the new technology has a downside. While it can restore health for many, in other cases it merely prolongs dying-- preserving only a semblance of life artificially maintained without hope of recovery. Both health care professionals and their patients have become increasingly concerned that medical technology can make dying with dignity more difficult.

Advance directives concerning health care in terminal cases -- what are colloquially called living wills-- have been adopted by increasing numbers of people as a mechanism to insure that they will be allowed to terminate treatment when death is near. Physicians are now routinely consulted about living wills by their patients, and called upon to honour them. Lawyers are now often asked to draft such documents. Both national and provincial organizations have been established to publicize the living will, and the concept has attracted considerable attention in the media. In fact, since the preparation of this report for publication, the issues discussed in it have been brought into sharp public focus by the case of Nancy B., a 25 year old quadriplegic able to breathe only with a mechanical respirator, who was permitted to refuse life-support by the courts (Quebec Superior Court, unreported, January 6, 1992).

While the common law recognises a right to refuse medical treatment, the status of advance directives in Saskatchewan law is uncertain. Clarification of the law is urgently required. The Commission's *Proposals for an Advance Health Care Directives Act* recommends recognition of advance directives that meet minimal formal requirements. The proposed legislation would protect physicians from liability who act in good faith in accordance with a directive.

It should be noted that the legislation would apply only to termination of treatment in a "last illness" in accordance with directions made by a patient who was fully competent at the time the directive was made. It does not, therefore, concern itself with active euthanasia.

Pursuant to Section 9 of The Law Reform Commission Act, the Commission now submits this report recommending enactment of an *Advance Health Care Directives Act*.

Respectfully submitted this 7th day of January, A.D. 1992.

Dale G. Linn, Q.C.,
Chairman.

Madam Justice Marjorie Gerwing,
Commissioner.

Gordon J. Kuski, Q.C.,
Commissioner.

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CHAPTER 1: DYING IN THE LATE TWENTIETH CENTURY

The capacity of modern medical science to sustain life is one of the greatest achievements of the twentieth century. Only sixty years ago, virulent disease routinely controlled today by antibiotics took uncounted lives annually. Victims of cardiovascular disease diagnosed as hopeless cases only two decades ago now look forward to years of productive and active life. The "conquest of disease" is a reality.

The conquest of death is a different matter. Every life must eventually come to an end. And in the end, all that anyone can hope for is to die without prolonged suffering and with as much dignity as reality permits. Paradoxically, the very technology that sustains and prolongs life also has the capacity to make dying more difficult. Consider, for example, the case of a terminal cancer patient reported in the *British Medical Journal*:

> An operation was performed to deal with the cancer, but it had spread far and wide. Part of the stomach was removed and the diagnosis was confirmed. Analgesic drugs to deaden pain and even morphine injections at night only partially controlled the pain, as the growths had spread to the spine and were pressing on the nerves. Ten days after the operation a blood clot suddenly blocked one of the arteries of the lungs. This might have proved rapidly fatal had not an emergency operation removed the clot. The patient expressed his appreciation of the good intentions of the young surgeon, but asked if other complications occurred no steps should be taken to prolong his life. He wrote a note to this effect on his case records. Two weeks later, he had another coronary thrombosis but was resuscitated by the hospital's emergency team. That night his heart stopped four times; each time it was restarted artificially. He lingered on for three more weeks, but, perhaps fortunate for him, his brain was not functioning as he was unconscious. Intravenous fluids were fed to him and antibiotics prevented infections. On the last day plans were made to help his failing breathing by an artificial respirator but the heart stopped before this endeavour could be realized.[1]

It cannot be pretended that the dilemmas presented by cases such as this one are easy to resolve. Death is difficult to accept - perhaps particularly so in our increasingly secular society. Ernest Becker, a cultural anthropologist, has written perceptively of the "denial of death" in western civilization.[2] This deep rooted attitude makes it difficult for the patient, the medical personnel in attendance, and the families of the terminally ill to respond appropriately when death has become inevitable.

Physicians have traditionally seen their primary mandate as the preservation of life at all cost. It has been suggested that

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[1] W.St.C. Symmers, British Medical Journal 1 (1968, p.442, as summarized in Hugh Trowell, The Unfinished Debate on Euthanasia, London: SCM Press, 1973, p.29.

[2] Ernest Becker, The Denial of Death, New York: The Free Press, 1973.

> [S]uccess or failure, according to one concept of medicine, is measured by the quality, strength and aggressiveness of the struggle waged. From this point of view, an aggressive struggle represents excellence in the practice and art of medicine.[3]

More and more physicians, however, doubt that this approach to health care for the terminally ill was ever satisfactory. As the King's College Centre of Medical Law and Ethics noted in a recent report, there is a growing awareness that the ethic represented by the traditional view involves a certain myopia, an unwillingness to address critical issues in terminal care:

> [H]ealth care professionals often deal badly with the dying. The reasons are numerous and complex: lack of awareness of the type and degree of pain and other symptoms; lack of knowledge concerning the best therapy for a specific symptom; poor awareness of the attitudes and wishes of both parents and relatives.[4]

But it is, above all else, advances in medical technology that have led many professionals and to recognise the need for a new ethic. Some eighty percent of patients die in institutions,[5] where an increasingly sophisticated panoply of life-prolonging technology is now available. The Law Reform Commission of Canada observes that

> [A]vailable medical technology is readily made use of, even sometimes where it serves no real therapeutic benefit but merely temporarily delays a death which has become imminent and inevitable. Prolonging the lives of certain terminally ill patients by these means may at a certain point become incompatible with considerations of the quality of life remaining to them. Such prolongation may, in fact, considerably lessen the quality of the remaining period of life. The decision to make use of medical technology is, unfortunately, sometimes based largely on technological criterion (whether it is technically possible), rather than on considerations for the patient himself (whether it is humanly desirable). An equation is made between what can be done and what should be done.[6]

Dr. Harry Emson puts the ethical dilemma created by this state of affairs succinctly - "[O]ur technological ability to manipulate the human body exponentially exceeds our moral capacity to decide on such manipulation."[7]

Faced with this reality, the medical profession has begun to place more emphasis on palliative care, quality of life, and the wishes of the terminally ill to die with dignity. As

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[3] Law Reform Commission of Canada, Euthanasia, Aiding Suicide and Cessation of Treatment (Working Paper 28), 1982, p. 4. See also the Commission's study paper by Edward W. Keyserlingk, Sanctity of Life or Quality of Life in the Contexts of Ethics, Medicine and Law, 1979.

[4] The Living Will: Consent to treatment at the end of life, Report under the auspices of Age Concern Institute of Gerontology and Centre of Medical Law and Ethics, King's College, London: Edward Arnold, 1988, p.12.

[5] "Is death on demand in the best interest of society?", The Toronto Globe and Mail, July 12, 1990.

[6] Euthanasia, Supra, Note 3, pp. 5-6.

[7] H.E. Emson, Rationing Health Care: Where Does The Buck Stop?, (1983) CMAJ vol. 128, p.435.

Margaret Somerville, Director of McGill University's Centre for Medicine, Ethics and Law has suggested, withholding or stopping medical treatment instead of doing everything possible to prolong life "is becoming the norm, and that is a big change from years ago."[8] The Canadian Medical Association's Code of Medical Ethics has been amended to recognize the right of a patient to die with dignity.[9] In Saskatchewan, Dr. Harry Emson, a pathologist and medical ethicist, has championed a shift toward greater sensitivity to the wishes of terminally ill patients to die with dignity.[10]

The relatives of terminally ill patients face dilemmas as acute as those of physicians. There may be an initial denial of the reality that death of a loved one is inevitable. Conflicting with this may be a feeling that the patient's suffering is unnecessarily prolonged. Yet, the next of kin of the patient will often be called upon to assist in making life-and-death decisions. Many physicians now regard involvement of relatives as good medical practice when a decision to terminate treatment is being considered. Moreover, involvement of family members is a social expectation. A poll conducted in 1990 for *Time Magazine* and Cable News Network found that

> Eighty percent of those surveyed said decisions about ending the lives of terminally ill patients who could not decide for themselves should be made by their families and doctors rather than by lawmakers.[11]

This poll confirms other research findings. For example, a survey of non-institutionalized elderly in Florida found that ninety percent expected family members to be involved in a decision about termination of treatment.[12]

It is, of course, the terminal patient whose dilemma is most acute. Some, like Dylan Thomas, may "rage against the dying of the light" until the end. For most, anger and depression ultimately give way to acceptance.[13] Once death's inevitability has been accepted, the problem facing the patient may be to persuade those about him or her to permit the death to occur with dignity, without prolonged suffering, and without heroic attempts to preserve a mere biological existence. The Anglican Church of Canada's Task Force on Human Life observed that

> The dying person may look for meaning in his suffering and, finding none, wishes

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[8] "Doctors becoming more willing to let terminally ill die in peace", The Toronto Globe and Mail, June 19, 1990.

[9] See commentary in Dr. C. Stuart Houston, "Living Wills: A Solution to the Prolonged Act of Dying?", (1988) CMAJ vol. 139, p.241.

[10] See Dr. Harry Emson, "The Living Will - An Option", Saskatoon Star-Phoenix, June 2, 1990.

[11] Nancy Gibbs, "Love and Let Die", Time Magazine, March 19, 1990.

[12] See Hugh M. Dallas, "All in the Family - Extended Autonomy Expectations in Surrogate Health Care Decision-making", Gerontologist, (1988) Vol. 20, (Supplement), pp. 46-51.

[13] See Elizabeth Kubler-Ross, On Death and Dying: What the Dying Have to Teach Doctors, Nurses, Clergy and Their Own Families, London: The McMillan Company, 1969.

> his life would soon end. At the same time, he wonders if he has any right to ask other people to hasten his death. He becomes very conscious that people are avoiding him. "The nurses don't look me in the eye, and they avoid my questions. My family used to kiss me when they left but now they just pat me on the hand or wave goodbye at the door". The mature patient realizes day by day that he is being denied those things that have always been indicators of adulthood. No one asks him his opinion about his health. His freedom to decide what he will do, what he will wear, where he will go, is denied. When a problem is raised about some issue in the family, he is told not to worry. There is a constant denial of his role of a free, responsible individual, and as a result he may question to what extent he is still a person.[14]

For the dying patient, the prospect of being subjected to the indignity of deteriorating mental and physical capacities sustained only by repeated medical intervention serves to underline the question "Why is it so hard to die?"[15]

Nothing, as Doctor Johnson said, so concentrates the mind as the prospect of death. Physicians, relatives of dying patients and the terminally ill themselves - those who have faced the prospect of death - are increasingly committed to the proposition that heroic measures to prolong life without regard for the quality of life are inappropriate. In the *Time*-CNN poll referred to above, 81% of respondents expressed the opinion that "the doctor should be allowed to withdraw life-sustaining treatment" if a patient is unconscious but has left instructions to do so. An American Hospital Association poll conducted in 1983 similarly found a clear majority (75%) in favour of discontinuance of treatment where "there is little or no hope of recovery and leading a normal life"[16]. A British survey in 1984 found 75% in favour of the proposition that a physician should comply with a request to end a patient's life in a case of "painful incurable disease".[17]

In Canada, there is growing evidence of public interest in fostering ways to make death with dignity a reality for the terminally ill, reflected in the media[18] and in the growth of organizations such as Dying with Dignity. Dying with Dignity has distributed some 12,000 living

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[14] Lawrence Whytehead and Paul Chidwick, Dying: Considerations Concerning the Passage From Life to Death, Toronto: The Anglican Book Centre, 1980.

[15] The phrase is from Elizabeth Kubler-Ross, Death: The Final Stage of Growth, Inglewood: Prentice-Hall Inc., 1975.

[16] Handbook of Living Will Laws 1981-84, New York. The Society for the Right to Die, 1984, p.7.

[17] R. Jowell et. al. British Social Attitudes: The 1986 Report, London: Gower, Aldershot, 1986, p.159.

[18] See, for example, Joanne MacDonald, "A matter of life and death", Toronto Globe and Mail, Sept. 12, 1991; Alanna Mitchell, "Living wills becoming thorny issue", Toronto Globe and Mail, April 24, 1991; Patrick Martin, "For mercy's sake", Toronto Globe and Mail, June 30, 1990; Paul Watson, "Terminally ill deserve right to choose death, MD says", Toronto Star, May 7, 1989; "Living wills gaining greater acceptance", Regina Leader-Post, June 8, 1991; Jim Biss, "The legality of the living will undetermined", Saskatoon Star Phoenix, Feb. 23, 1990. Over treatment of terminally ill growing legal dilemma: expert", Saskatoon Star-Phoenix, June 6, 1989.

will documents across Canada over the past decade.[19] A Saskatchewan organization with similar goals, Saskatchewan Death with Dignity, has recently been formed. Many hospitals have adopted "Do Not Resuscitate" (DNS) orders as a standard procedure to implement the wishes of dying patients. Lawyers in Saskatchewan and elsewhere in Canada report that they are increasingly asked to prepare some form of "living will" for their clients, and the Saskatchewan Branch of the Canadian Bar has featured a discussion of living wills at a recent conference.[20]

The "living will" is a document executed by a competent adult directing that life-support or life-sustaining treatment be suspended when there is no longer any real prospect of recovery, or only the prospect of a much diminished quality of life in the future. In the United States, such "advance directives" have been given legal status in legislation. An alternative form of advance directive has also been adopted in some American jurisdictions, and in the province of Nova Scotia.[21] This is a form of "enduring power of attorney", conferring decision-making power in regard to termination of treatment on a designated relative or friend in the event that the patient becomes incompetent.

In Canada, the legal status of advance directives is uncertain. Apart from the Nova Scotia statute, there is no legislation on the topic, though a bill giving legal status to advance directives has been introduced in the Ontario legislature,[22] and legislation has been recommended by the Manitoba Law Reform Commission.[23] The common law recognises that a patient has a general right to refuse medical treatment, but the circumstances which would justify acceptance of a terminal patient's desire to discontinue treatment remain uncertain.

Legislation to give recognition to some form of advance directive is overdue. The law cannot solve the ethical and personal dilemmas surrounding death in our technological age. It should recognize, however, the growing demand for the right to die with dignity. Legislation should facilitate the efforts of the medical profession, the relatives of terminal patients, and terminal patients themselves to come to grips with the reality of death. The law should not provide yet another set of problems to be coped with in the final crisis of life.

In this report, the feasibility of adopting advance directives legislation in Saskatchewan will be discussed. It addresses only a sub-set of the legal and ethical problems surrounding the notion of death with dignity, however. An advance directive statute will do no more nor less than permit a competent adult to provide instruction in regard to medical treatment in cases in which the prospect of continued life of a quality acceptable to the patient is no longer possible. At least three other related but distinguishable matters lie outside the scope of this report.

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[19] See Mitchell, note 16.

[20] The Saskatchewan CBA Midwinter Meeting, 1991. A draft version of part of this report was presented at the meeting.

[21] See below, chapter 4.

[22] "Living wills legislation introduced in Ontario", Toronto Globe and Mail, May 28, 1991. A private member's bill to recognise living wills was introduced in the Alberta legislature in 1977, but failed to pass.

[23] Manitoba Law Reform Commission, Advance Directives and Durable Powers of Attorney for Health Care, July, 1990.

First, this report does not directly address the termination of life-saving as a opposed to life-sustaining procedures. For example, an adult Jehovah's Witness may refuse a blood transfusion on religious grounds, even though death is likely if the transfusion is not performed, and complete recovery is probable if the transfusion is performed. There is, in fact, developing law on this issue in Canada. Some of it will be discussed below, but only because it is indirectly relevant to the legal status of advance directives in cases involving life-sustaining procedures during a final illness.

Second, this report is not concerned with the question of termination of treatment in cases in which the patient is "brain dead". The issues involved in such cases are conceptually quite different. The Commission's report, *Proposals for a Definition of Death Act*, recommended that legislation be adopted recognizing that "death is the total and irreversible cessation of brain function". This corresponds to generally-accepted medical practice. If a patient is judged to be dead on both medical and legal criteria, the decision to terminate procedures that maintain respiration and heartbeat is no longer one in which the wishes of the patient, expressed in advance, are of central relevance.

Thirdly, this paper does not deal with euthanasia in the broad sense of the term. While termination of treatment in accordance with an advance directive may be regarded as a form of voluntary euthanasia, the term is more usually applied to cessation of treatment or some active step to end life where the patient has not, or cannot, provide direction. Involuntary euthanasia is outside the scope of this report.

A distinction may also be made between "active" and "passive" euthanasia. The latter involves only a cessation of treatment. In the case of a patient who wishes to be permitted to die, it represents nothing more than respect for the patient's refusal to consent to further treatment. Most advance directives go no further than this; a living will is a manifestation of a refusal to consent to specified treatment made in advance of the circumstances in which it is to be used. Active euthanasia, for a patient who wants to terminate a painful or hopeless life, involves administration or assistance in the self-administration of drugs intended to end life. Active euthanasia has only recently begun to attract public attention. Debate about active euthanasia has been spurred by the tragic dilemmas faced by persons suffering from AIDS and increased concern about the quality of life of victims of other degenerative conditions such as Alzheimer's Disease.

There is little consensus about active euthanasia, either among the public or ethicists and health care workers. Some philosophers see no difference between active and passive euthanasia. Other ethicists see the distinction as vital. Thus, for example, the Vatican has recently reaffirmed the proposition that "mercy killing" is forbidden to Catholics, but distinguished a terminal patient's refusal to consent to treatment, characterizing such a decision as "acceptance of the human condition". In any event, as the next chapter will demonstrate, active euthanasia is probably contrary to the criminal law of Canada. Thus, provincial law authorizing a patient to request assistance in terminating his or her life would be outside the competence of the provincial legislature.

PROPOSALS FOR AN ADVANCE HEALTH CARE DIRECTIVES ACT

The legal and ethical questions surrounding the issues identified here as beyond the scope of this report are as acute as those discussed in the paper. However, from both legal and ethical points of view, the limited focus is justified. There is an emerging consensus in favour of legal recognition of advance directives; the same cannot be said about euthanasia in the broader sense. This report investigates the options for legislative innovation within the parameters of the new consensus.

CHAPTER 2: THE LEGAL BACKGROUND

1. The Right to Refuse Medical Treatment in Canadian Law

Our legal and social order is based on the assumption that adult citizens are to be treated as free-willed and autonomous individuals. John Stuart Mill reflected this common law principle when he wrote that "each person is the proper guardian of his own health, whether bodily, or mental, or spiritual".[24] A doctor must ordinarily obtain the patient's consent before undertaking a regime of treatment. That legal rule protects the rights of the individual, and is one of the principal tools in our law for the regulation of the practice of medicine. Technically, any interference with an individual that is not consented to amounts to an assault. Medical treatment without consent is, therefore, tortious. This is true even if the medical treatment provided appeared to the physician to be medically necessary, and was competently administered. Thus, for example, in an Alberta case, *Mulloy v. Hop Sang*, an accident victim recovered damages from the physician under these circumstances:

> [The physician] was called to the hospital and [Hop Sang], being a stranger and unacquainted with the [physician], asked him to fix up his hand but not cut it off as he wanted to have it looked after in Lethbridge, his home city. Later on in the operating room the defendant repeated his request that he did not want his hand cut off. The doctor, being more concerned with relieving the suffering of the patient, replied that he would be governed by conditions he found when anaesthetic had been administered.....On examination he decided that an operation was necessary and the hand was amputated. Dr. Mulloy said the wounds indicated an operation as the condition of the hand was such that delay would mean blood poisoning with no possibility of saving it.[25]

The common law doctrine of consent has recently been given new status by *The Charter of Rights and Freedoms*. In a 1991 Ontario case, *Fleming v. Reid; Fleming v. Gallagher* (unreported), legislation permitting treatment without consent of a patient committed to a psychiatric facility who had made an advance directive prior to committal was struck down. The court held that

> To deprive involuntary patients of any right to make competent decisions with respect to such treatment when they become incompetent...clearly infringes their Charter right to security of the person.

But whether the right to refuse treatment extends to cases in which the refusal is clearly

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[24] J.S. Mill, Utilitarianism, On Liberty etc., London: Everyman's Library Edition, 1910.

[25] Mulloy v. Hop Sang [1935] 1 W.W.R. 714 (Alta. C.A.).

life-threatening has been regarded, at least until very recently, as less clear in Canadian law. At an early date, the common law concluded that there are limits on the doctrine of consent. Sir James Stephen summarized the state of the law the late nineteenth century in his *Digest of the Criminal Law:*

> No one has a right to consent to the infliction upon himself of death, or of an injury likely to cause death...or to consent to the infliction upon himself of bodily harm amounting to a maim....[26]

This proposition has suggested to some commentators that a refusal to accept medical treatment in a life-threatening situation is illegal, and thus affords a physician who provides treatment without consent a defence. Others regard this limit on the doctrine of consent as inapplicable to cases involving a refusal to consent to medical treatment. In 1929 the Saskatchewan Court of King's Bench rather reluctantly concluded that a patient has a common law right to refuse even a potentially life-saving medical operation.[27] In the United States, recent decisions have upheld the right to die with dignity. For example, in *Bouvia v. Superior Court of the State of California*[28], a competent cerebral palsy victim was held to have the right to refuse tubal feeding. Some English authorities, on the other hand, suggest that a physician may over-ride the patient's wishes in order to save life.[29] No Canadian decision gave rigorous consideration to the issue in a contemporary context until the Ontario case of *Malette v. Shulman* in 1987.[30]

The plaintiff, Georgette Malette, was injured in a motor vehicle accident. She arrived at the hospital unconscious, and the defendant, Dr. Shulman, determined that a blood transfusion was necessary to save her life. Before the blood transfusion was administered, a nurse discovered a card in the plaintiff's wallet identifying her as a Jehovah's Witness, and stating that, because of religious convictions, she be given no blood transfusion under any circumstances. The card further stated that "I fully realize the implications of this position, but have resolutely decided to obey the Bible command: Keep abstaining...from blood." Dr. Shulman obtained a second medical opinion that the blood transfusion was necessary, and proceeded to administer it. While this therapy was still underway, Mrs. Malette's daughter arrived at the hospital with a local church elder. They both objected to continuation of the transfusion. Dr. Shulman continued to administer blood until he was satisfied that his patient was out of danger. Mrs. Malette was awarded damages

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[26] Sir James Stephen, A Digest of the Criminal Law, (7th Edition), London: Sweet and Maxwell, 1926.

[27] Masny v. Carter-Halls-Aldinger Co. Ltd. [1929] 3 W.W.R. 741.

[28] (1986) 225 Cal Reptr 297.

[29] e.g. Leigh v. Gladestone (1909) 26TLR 139; Re Stone [1977] QB 354. These cases have been severely criticized- see e.g. Kennedy, "The Legal Effect of Requests by the Terminally Ill and Aged not to Receive Further Treatment from Doctors", Criminal Law Review, 217-32.

[30] 43 C.C.L.T. 62.

for assault at trial, and the decision was subsequently upheld by the Ontario Court of Appeal.[31]

In the Court of Appeal Mr. Justice Robins premised his analysis of the issue on the principle that any interference with the human body without consent is a tort:

> The right of a person to control his or her own body is a concept that has long been recognized at common law. The tort of battery has traditionally protected the interest in bodily security from unwanted physical interference....No special exception is made for medical care. Other than in emergency situations, the general rule governing actions for battery are applicable to the doctor-patient relationship.

He clearly recognized that tort law is "the primary means of protecting a patient's right to control his or her medical treatment", and that as a necessary implication

> The right of self-determination which underlies the doctrine of informed consent also obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternative form of treatment, even if this decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment.

Two lines of defence were advanced on Dr. Shulman's behalf. First, he relied upon the so-called emergency treatment doctrine. As Robins put it:

> The emergency situation is an exception to the general rule requiring a patient's prior consent. When immediate medical treatment is necessary to save the life or preserve the health of a person who, by reason of unconsciousness or extreme illness, is incapable of either giving or withholding consent, the doctor may proceed without the patient's consent.

The emergency treatment doctrine is a well-established common law principle, and an obvious necessity if medical treatment is not to be denied accident victims and others in need when a consent cannot be obtained.[32] However, the circumstances which make the emergency doctrine necessary do not, on their face, extend to situations in which the patient has, before becoming unconscious or incompetent, specifically refused the medical treatment which seems to be required

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[31] (1990) 72 O.R. (2nd) 417.

[32] See Parmley v. Parmley [1945] D.L.R. 81 (S.C.C.) - "There are times under circumstances of emergency when both doctors and dentists must exercise their professional skill and ability without the consent that is required in the ordinary case. Upon such occasions great latitude may be given to the doctor or dentist." (Per Estey J.).

in the emergency. Robins had no difficulty distinguishing the case before him from those in which the emergency treatment doctrine had been applied. He concluded that

> A doctor is not free to disregard a patient's advance instructions any more than he would be free to disregard instructions given at the time of the emergency. The law does not prohibit a patient from withholding consent to emergency medical treatment, nor does the law prohibit a doctor from following his patient's instructions. While the law may disregard the absence of consent in limited emergency circumstances, it otherwise supports the right of competent adults to make decisions concerning their own health care by imposing civil liability on those who perform medical treatment without consent.

There was surprisingly little authority on this point prior to the *Malette* case. Nevertheless, the conclusion reached by Robins is the only one possible that is consistent with both the emergency treatment doctrine and the principle that a patient may refuse medical treatment. Robins followed the logic of a leading American text on tort law, Prosser and Keeton, which similarly concluded that the emergency treatment doctrine applies only if "under the circumstances, a reasonable person would consent and the probabilities are that the patient would consent."[33]

Dr. Shulman also argued, however, that he was entitled to discount the Jehovah's Witness card as a manifestation of refusal to accept treatment in the emergency. It was suggested that a refusal to accept medical treatment must be an informed refusal. It would seem that the real basis for this argument is a simple analogy. It is settled law that a consent to medical treatment must be informed. If a physician proposes treatment to the patient, he or she must also make disclosure of all the "material and special risks" which "would influence a person's consent to treatment".[34] What was really at issue in *Malette* was whether the converse of this statement is also true: Can a patient refuse treatment without being informed of the consequences of the refusal? Superficially, some authoritative statements of the law of consent might appear to give some credence to the proposition advanced on Dr. Shulman's behalf. Thus, for example, in *Reibel v. Hughes*[35], the Supreme Court of Canada stated that the basic requirement is

> ...what the average prudent person, the reasonable person in the patient's particular position, would agree to or not agree to, if all material and special risks of going ahead with the surgery or foregoing it were made known to him.

But it must be remembered that this proposition was stated in the context of a case in which a physician had proposed a course of treatment to a patient and was asking for the patient's consent. It is not directed to cases in which a patient simply and unilaterally indicates that he or she will

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[33] 5th Ed. (1984), at p. 118. See also F.A. Rozovsky, Consent to Medical Treatment: A Practical Guide, Toronto: Butterworths, 1984. Rozovsky states that there must be no indication that the patient would withhold consent.

[34] Hop v. Lepp [1980] 2 S.C.R. 192.

[35] [1980] 2 S.C.R. 880.

not submit to specified treatment. As Robins noted, in the *Malette* case

> It is apparent that the doctor could not inform the patient of the risks involved in her prior decision to refuse consent to blood transfusion in any circumstances. It is apparent also that her decision did not emerge out of a doctor-patient relationship. Whatever the doctor's obligation to provide the information needed to make an informed choice may be in other doctor-patient relationships, he cannot be in breach of any such duty in the circumstances of this relationship.

Rather, in the *Malette* case, the patient simply refused treatment. The physician ignored the refusal. Since there was no consent, it would seem difficult to avoid the conclusion that the doctor's subsequent actions amounted to an assault. As Mr. Justice Cardozo put it in a classic statement of the consent doctrine:

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body....It is immaterial whether any other person would have found the procedure necessary, so long as this particular person specifically refused it.[36]

Finally, Robins also considered the question of whether an overriding state interest in protecting and preserving the life and health of its citizens would justify ignoring Mrs. Malette's refusal to accept treatment in a life-threatening situation. In the United States, several cases have limited the right of self-determination on this basis. Whether they are still good law in the United States is open to question. They all date to the 1960's, prior to the more recent *Bouvia* decision. As F.A. Rozovsky has stated, "The tenor of the times is [now] one of respect for the bodily integrity of the person."[37] Robins did not consider the American authorities, but did note that there are some cases in which the state interest would override the individual interest. He suggested that:

> For example, the state may in certain cases require that citizens submit to medical procedures in order to eliminate a health threat to the community or it may prohibit citizens from engaging in activities which are inherently dangerous to their lives.

But he had no doubt that:

> The state's interest in preserving the life or health of a competent patient must generally give way to the patient's stronger interest in directing the course of her own life.

On the facts of the *Malette* case, he concluded that a case had not been made that an identifiable state interest outweighed Mrs. Malette's right to refuse treatment.

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[36] Schoendorf v. Society of New York Hospital (1914), 105 N.E. 92.

[37] Rozovsky, Supra, note 34.

The *Malette* decision is strong authority for the proposition that a patient may refuse medical treatment in an advance directive, even if death is a likely or probable consequence of the refusal. Obviously, the decision has clear and important implications for the topic under consideration here. However, it is perhaps premature to conclude that the *Malette* decision is certain authority for the proposition that living wills and similar arrangements are legally binding in Canada. Mr. Justice Robins himself warned against this conclusion. He stated that:

> I should emphasize that in deciding this case the Court is not called upon to consider the law that may be applicable to many situations in which objection may be given to the use or continued use of medical treatment to save or prolong a patient's life. The Court's role, especially in a matter as sensitive as this, is limited to resolving the issues raised by the facts presented in this particular case. On these facts, we are not concerned with a patient who has been diagnosed as being terminally or incurably ill who seeks by way of advance directive or living will to reject medical treatment so that she may die with dignity; neither are we concerned with the patient in an irreversible vegetative state whose family seeks to withdraw medical treatment in order to end her life; nor is this a case in which an otherwise healthy patient wishes for some reason or other to terminate her life. There is no element of suicide or euthanasia in this case.

It might be possible to dismiss the passage quoted above as simply a manifestation of judicial conservatism, of adherence to the principle that a decision should decide no more than is required on the facts before the court. However, at least two aspects of the *Malette* decision suggest that the transition from the circumstances which existed in that case to the circumstances in which the validity of a living will might be considered is problematic. Robins gave little attention to the so-called "doctrine of informed refusal". He did not think it necessary to consider whether, in the context of a subsisting doctor-patient relationship, a doctor is under an obligation to provide sufficient information to a patient to permit the patient to make a decision about whether to refuse medical treatment. It is at least possible that a court might distinguish a case in which a patient drew up a living will after consulting with a physician from one in which consultation did not occur, or was impractical.

Second, Robins was prepared to accept the proposition that the state interest in maintaining the life of its citizens might outweigh an individual's right to refuse treatment in some cases. Just what those cases might be, was left open. However, it is at least worth noting that Robins was in part impelled to reject the state interest argument because a matter of deep religious conviction was involved. Whether a "mere" desire to end a life that has become painful and pointless to the patient, or to terminate a treatment regime that subjects the patient to indignities, would be sufficient to override the state interest in preserving life was left undecided.

2. Substitute Decision-making in Canadian Law

When a patient is no longer able to make decisions for himself or herself, most physicians regard it as good practice to consult with the immediate family. Social Workers involved in

palliative care programs and as counsellors to dying patients and their families suggest that such consultation is almost always desirable. As the public opinion surveys referred to in the first chapter indicate, consultation is also a common expectation of both patients and their families.

Consider, for example, a recent case at the Royal University Hospital in Saskatoon. The patient, an elderly man with a quite limited life expectancy, suffered from kidney failure. He had received dialysis for this condition on several occasions, and realized that at best the treatment would postpone his death for a short time. He concluded that he did not wish to be subjected to the treatment again, and instructed his doctor not to begin the procedure should it be required. The physician, though sympathetic to the patient's desire to retain his dignity in his last days, was concerned that the patient's physical state might be affecting his capacity to consent to or refuse medical treatment. Therefore, a geriatric psychiatrist was brought in as a consultant on the case. In addition, family members were also consulted. The family had discussed the patient's decision to forego treatment with him, and concluded that his wishes should be respected. The psychiatrist concluded that the patient was mentally competent. In the result, the patient was allowed to die.

One element of the practice adopted in the case outlined above was the involvement of the family as substitute decision-makers for the patient. An advance directive might attempt to formalize such a practise by delegating decision-making power to a family member in the event that the patient becomes unable to make a decision himself or herself. It has also been noted above that in some jurisdictions, provision can be made for appointment of a substitute decision-maker in an enduring power of attorney. However, short of a specific legislative sanction for appointment of a substitute, there is little authority for the proposition that family members have a right at common law to be involved in a medical decision.

A relative is not a legal guardian unless he or she has been appointed by the court. It has been suggested by some commentators that physicians who rely on directives from relatives are in a tenuous legal position, and may be subject to civil proceedings.[38]

Several cases in the United States have dealt with this issue, primarily in the context of a dispute between a physician and the family of an unconscious patient in regard to the medical treatment which should be provided. In *Re Severns* (1980), 425 a. 2nd 156 and in *John F. Kennedy Memorial Hospital v. Bludworth* (1984) 452 S.O. 2nd 921, the courts applied a substituted judgment test to determine what treatment should be followed. The court turned to a relative for evidence to enable it to determine what the incompetent patient's wish would have been. In *Barber and Nejdl v. Superior Court* (1983) 195 Cal. Rptr. 484, the court went so far as to find that a spouse was an appropriate person to act as a surrogate for the patient. But the *Barber* case may be anomalous since it involved a murder charge against physicians who omitted to continue

[38] See e.g. G. Sharp and G. Sawyer, Doctors and the Law, Toronto: Butterworths, 1979; G. Sharp, The Law and Medicine in Canada, 2nd Ed., Toronto: Butterworths, 1987; and P.D.G. Skegg, Law, Ethics and Medicine, Oxford: Clarendon Press, 1984.

treatment when the wife was in agreement with the physicians that treatment should be discontinued. None of the other American authorities appear to go as far as suggesting that physicians can routinely turn to family members as substitute decision-makers without advance court approval.

In Saskatchewan, there may be some legislative sanction for recognition of a family member as a substitute decision-maker. Section 90 of the Saskatchewan *Public Health Act*[39] gives specific authorization to a physician or dentist to administer treatment to a person incapable of consent if consent is obtained from the nearest relative, or if there is no nearest relative or the nearest relative cannot be found, with the written concurrence of another physician. The *Act* states that treatment must be "in such manner and to such extent as is reasonably necessary and in the best interest of the person." The statute provides a formula for determining who is the "nearest relative" for purposes of obtaining the consent.

It is likely that this provision was enacted to provide physicians with an alternative to the emergency treatment doctrine. Fear of legal liability when no consent has been obtained has always been a factor discouraging physicians from providing emergency treatment. While the emergency treatment doctrine theoretically provides a defence, the defensive shield may be broken if it is concluded by the court that no true emergency existed, or that the treatment was not entirely appropriate. But whatever the original purpose of the section, it would appear on its face to be of some relevance in a case in which family members believe an unconscious relative should be permitted to die. If the nearest relative is authorized in law to consent to treatment, it follows that the nearest relative may also withhold consent. But it is not so clear that a refusal to consent in a life-threatening situation in order to permit the patient to "die with dignity" is authorized by *The Public Health Act*. The *Act* requires that the treatment be "in the best interest of the person". It is begging the question to conclude that a right to die with dignity is unequivocally in the best interest of the individual, at least as judicial attitudes stand today.

Saskatchewan also has legislation authorizing enduring powers of attorney. But this legislation is likely limited, unlike the Nova Scotia enduring powers of attorney legislation which specifically mentions health care, to grants of authority to an "attorney" or substitute- decision maker in regard to property and financial matters. The President's Commission Report, *Deciding to forego life-sustaining treatment*, examined similar legislation in force in American jurisdictions, and concluded that it did not extend to health care matters.[40]

3. Criminal Law and the Right to Die with Dignity

Section 14 of the *Criminal Code* provides that:

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[39] R.S.S. 1978, c. P-37.

[40] Washington: U.S. Government Printing Office, 1983, p.147.

> No person is entitled to consent to have death inflicted upon him, and such consent does not affect the criminal responsibility of any person by whom death may be inflicted upon the person by whom consent is given.

Section 224 further provides that:

> Everyone who (a) counsels a person to commit suicide, or (b) aids or abets a person to commit suicide, whether suicide ensues or not, is guilty of an indictable offence....

As Douglas A. Schmeiser has written, "a doctor who 'kills' a patient begging to be put out of his misery is guilty of murder, ignoring for the moment the ambiguity of the word 'kills'."[41] It would seem that active euthanasia is clearly prohibited under this section of the *Criminal Code*. It is unlikely, however, that the section would apply to a decision not to provide treatment, or to discontinue treatment after it has begun. The authors of the Centre of Medical Law and Ethics report on living wills, commenting on English provisions similar to sections 14 and 224 of the *Code*, concluded that:

> We reject the view that in withdrawing or withholding artificial hydration or nutrition the physician assists suicide. We take the view that even if the patient is not suffering from terminal illness .... starvation is not suicide. Furthermore, even if the law were to regard the patient as committing suicide, the doctor's *omission* to continue artificial feeding or hydration would not be regarded as assistance.[42]

Section 198 of the *Criminal Code* may also be relevant when treatment is terminated. The section provides that

> Everyone who undertakes to administer surgical or medical treatment to another person or to do any other lawful act that may endanger the life of another person is, except in cases of necessity, under a legal duty to have and use reasonable knowledge, skill and care is so doing.

In addition, section 199 provides that:

> Everyone who undertakes to do an act is under a legal duty to do it if an omission to do the act is or may be dangerous to life.

The import of these provisions is not, of course, entirely clear. Nevertheless, they might well be

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[41] Douglas A. Schmeiser, Living Wills and Medical Treatment of the Terminally Ill, Unpublished Manuscript, January 12, 1989.

[42] See note 2, p.29.

interpreted by a court that gave precedence to preservation of life over quality of life as requiring a physician who has undertaken to provide treatment to continue the treatment with as much skill as he or she possesses, regardless of the circumstances. Coupled with section 14, these sections might make a physician criminally liable for discontinuance of treatment. Cynthia Baker, in a 1980 article on living wills in Canada, concluded that the *Code* provisions "logically would cover the situation where [a physician]...withdraws life-prolonging or sustaining technology from a dying patient."[43]

But while the sections of the Criminal Code outlined above clearly create some potential liability for doctors following advance directives, it is by no means certain that the Criminal Code is a real impediment, except in cases of active euthanasia. It is quite possible that in the contemporary climate of opinion, sections 198 and 199 of the Criminal Code would be interpreted as requiring a physician to do no more than good medical practice requires, which might include a termination of treatment in a hopeless case. There is very little authority on this issue. No physician has been prosecuted in Canada for withdrawing treatment at a patient's request. It is worth noting, however, that in an English case, *R. v. Adams*[44], Lord Devlin reached the conclusion that a doctor is entitled to take measures to relieve suffering even if the measures "will incidentally shorten life by hours or perhaps even longer". It is also worth noting that in the *Malette* case there was no suggestion that any criminal liability might fall upon the head of a doctor who respects a patient's refusal to accept medical treatment, even in a life-threatening situation.

The Law Reform Commission of Canada's 1982 working paper, *Euthanasia, Aiding Suicide, and Cessation of Treatment*[45], reached the conclusion that there is an "already established rule that there should be no duty to initiate or maintain treatment when it is useless to do so".[46] The Commission also noted that:

> Some argue, with some logic on their side, that legislative reform in this area is not necessary. They point out, more particularly, that the sections of the Criminal Code which we have analyzed, unlike other sections of the Code, have not yet raised any serious problems in terms of practical application....Moreover, as we have seen, these provisions are very rarely applied to the medical and hospital context.[47]

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[43] Cynthia H. Baker, "The Living Will: The Final Expression", Legal Medical Quarterly, Spring, 1980, p.2.

[44] (1957) Crim.L.R. 365.

[45] Law Reform Commission of Canada, Working Paper 28, 1982.

[46] Ibid, p. 69.

[47] Ibid, p. 27.

Although the Commission did ultimately recommend some amendments to the *Criminal Code* to prevent misapplication of the provisions discussed above[48], it would appear that the criminal law creates no insurmountable obstacle to recognition of advance directives, at least in so far as the legislation does not authorize a patient to consent to what amounts to "active euthanasia".

[48] The recommendations included the propositions that:

1. Nothing in sections 14, 45, 198, and 199 of the Criminal Code shall be interpreted as requiring a physician (a) to continue to administer or to undertake medical treatment against the clearly expressed wishes of the person for whom such treatment is intended; (b) to continue to administer or undertake medical treatment, when such treatment is medically useless and is not in the best interest of the person for whom it is intended, except in accordance with the clearly expressed wishes of the person.
2. Nothing in sections 14, 45, 198 and 199 of the Criminal Code shall be interpreted as preventing a physician from undertaking or ceasing to administer palliative care and measures intended to alleviate or to relieve the suffering of the person for the sole reason that such care or measures are likely to shorten the life expectancy of this person.

CHAPTER 3: THE LIVING WILL

1. The Nature of the Living Will

The living will has become a popular form of advance health care directive throughout North America. The survey of elderly Floridians referred to in the first chapter found that ninety percent of the respondents had "heard of" the living will. Eighteen percent claimed to have signed such a document, and thirty-seven percent more said that they "might want to".[49] The *Time*-CNN poll found that eighty percent of Americans accepted the concept of the living will as a method of decision-making for terminally ill patients who could no longer make health care decisions for themselves. As early as 1974, the Euthanasia Council reported that its model living will had been signed by 750,000 Americans.[50] In Canada, no opinion surveys have been conducted, but there is undoubtedly a similar growth of interest in the living will. It was noted above that Dying with Dignity has distributed 12,000 living will forms in Canada. Lawyers and doctors in Saskatchewan report that they now are being asked to give advice concerning living wills on a increasingly frequent basis.[51] Many Canadians now have living wills or are interested in the concept.

As more than a few observers have noted, the term "living will" is something of a contradiction. It deals with dying, not living. It is not a will, which speaks only from death, but a direction to be implemented while the maker of the document still lives.[52] The term "advance health care directive" is undoubtedly more accurate. Nevertheless, the concept appears to be well understood by those who use the term "living will". Although living wills can take many forms, all are premised on the assumption that a patient should be able to give direction in advance concerning treatment in a crisis situation in which the patient can no longer consent to or refuse proposed medical aid.

As Rozovsky notes:

> Some directives or living wills are quite broad, ruling out the use of heroic or extraordinary treatment. In these instances it is up to the caregivers to fill in the

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[49] See Hugh M. Dallas, "All in the Family - Extended Autonomy Expectations in Surrogate Health Care Decision-Making", Gerontologist, (1988) Vol. 20, (Supplement), pp. 46-51.

[50] Vaughan, "The Right to Die", (1974) 10 Calif.L.Rev. 613.

[51] See Dr. C. Stewart Houston, "Living Wills: A Solution to the Prolonged Act of Dying?", (1988), CMAJ, Vol. 139, p. 241.

[52] Lorne Elkin Rozovsky and Fay Adrienne Rozovsky, The Canadian Law of Consent to Treatment, Toronto: Butterworths, 1990, p. 96.

> fine points of what constitutes unacceptable forms of care. Other well-drafted living wills are more specific. The documents rule out or approve the use of particular types of treatment. The directives may make reference to resuscitation efforts, antibiotics, ventilatory therapy, chemotherapy, radiotherapy and artificial tube feeding.[53]

The living will made available by the American Euthanasia Council is an example of a model drafted in broad terms. It is a fairly typical example of the living wills in use in Canada and the United States:

> **THE LIVING WILL**
>
> TO MY FAMILY, MY PHYSICIAN, MY CLERGYMAN, MY LAWYER: If the time comes when I can no longer actively take part in decisions for my own future, I wish this statement to stand as the testament of my wishes.
>
> If there is no reasonable expectation of my recovery from physical or mental and spiritual disability, I, _____, request that I be allowed to die and not be kept alive by artificial means or heroic measures. I ask also that drugs be mercifully administered to me for terminal suffering even if in relieving pain they may hasten the moment of death. I value life and the dignity of life, so that I am not asking that my life be directly taken, but that my dying not be unreasonably prolonged nor the dignity of life destroyed.
>
> This request is made, after careful reflection, while I am in good health and spirits. Although this document is not legally binding, you who care for me will, I hope, feel morally bound to take it into account. I recognize that it places a heavy burden of responsibility upon you, and it is with the intention of sharing this responsibility that this statement is made.

Let Me Decide, a recently-published book by Dr. David Molloy of McMaster University, represents the other extreme: most of the book consists of a draft living will and draft appointment of a substitute-decision maker, making detailed provision for treatment options.[54]

But whether the living will is drafted in broad or narrow terms, in detail or in generalities, it can take effect in Canada only as a manifestation of a refusal to consent to medical treatment. The discussion of the right to refuse medical treatment in Canadian law in the last chapter of this report suggests that living wills may have a legally-binding effect in Canada, but the uncertainty surrounding this question makes any categorical statement about the status of living wills

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[53] Ibid. p. 96.

[54] Hamilton: McMaster University Press, 1989.

problematic. At present, most physicians are more apt to regard a living will as a "guide or a framework for patient management"[55] than as a legally-binding document. Under current practice in Saskatchewan hospitals, when an advance directive is known to attending physicians, a psychological assessment of the patient and involvement of family members is often given equal weight with the patient's expressed wishes in determining a course of action.

2. Statutory Recognition of the Living Will

Obviously, the simplest way to resolve outstanding questions concerning the status of the living will would be to enact legislation expressly permitting patients to make advance directives, and setting out the legal consequences of the document as clearly as possible. No Canadian jurisdiction has enacted living wills legislation, though legislation is pending in Ontario. In the United States, on the other hand, living wills legislation has proliferated. Following adoption of the first *Natural Death Act* in California in 1976,[56] forty other States and the District of Columbia have adopted similar legislation.

The California legislation essentially authorizes a particular form of living will.[57] The document must be in writing, executed by the maker, and witnessed in accordance with the terms of the *Act*. An advance directive complying with the formal requirements will be effective to authorize withholding or withdrawing life-sustaining procedures intended only to postpone death in terminal cases, so diagnosed by two physicians. The legislation does not cover refusal to consent to treatment in other circumstances. Deliberate actions to terminate life - active euthanasia - are expressly forbidden. As Baker observes, "the purpose of the law is only to allow natural death to occur as the qualified patient has directed."[58]

The legislation attempts to build in certain safeguards to ensure that it reflects the patient's wishes at the last possible moment before it is acted upon. A fourteen day "cooling-off" period after the document is signed is imposed; during this time, the directive is not legally enforceable. If the patient is capable of doing so, the document must be re-executed after the patient is diagnosed as terminal. Similarly, the directive remains in effect for only five years unless the patient has become incompetent during that time. Finally, the directive may be revoked at any time without formalities by the patient, and without consideration of the competency of the patient at the time the revocation is made.

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[55] Supra, Note 52, p. 96.

[56] The California Health and Safety Code, Chapter 3.9.

[57] For summary and analysis of the legislation, see Cynthia H. Baker, "The Living Will: The Final Expression", Legal Medical Quarterly, Vol. 4, Spring 1980, pp. 7-8.

[58] Ibid, p. 8.

THE LIVING WILL

Although welcomed at the time it was adopted, the California *Natural Death Act* and its analogues in other jurisdictions have been subjected to considerable criticism.[59]

Some of the criticism directs attention to quite specific provisions in the *Act*. The five-year renewal clause and the fourteen day "cooling off period" have both been identified as unnecessary and unduly restrictive. The renewal clause may have the effect, in fact, of rendering the living will ineffective when the patient actually has need of it, but, because of declining physical and mental capacity, has not been able to effectively redirect his or her attention to the need. Baker comments that the clause

> may place an undue hardship on patients suffering from degenerative diseases, or the elderly, who due to senility may not be able to express themselves clearly five years hence. In contrast, it is pointed out that there is no such requirement concerning a will disposing of one's personal estate.[60]

The fourteen day "cooling off period" may make it impossible to give legal effect to an advance directive issued by an accident victim or other person entering an unexpected but critical phase of treatment. Baker suggests that there should at least be a "provision for bedside directives...in exceptional circumstances e.g. a burn patient".[61] Meyers[62] points out that a patient who has been on the critical list for fourteen days may not be sufficiently mentally alert to execute a living will and make it binding.

The formalities required to produce a legally-binding advance directive have been criticized as excessive.[63] It is interesting to note that "substantial compliance" legislation has recently been adopted in several provinces, including Saskatchewan, to relieve against the strict formalities traditionally required to create a proper will disposing of property. Such legislation reflects a concern that formalities designed to protect may actually defeat a testator's clearly-expressed intentions if too rigorously applied. Certainly, the same logic should be applied to living wills. Even the requirement that the advance directive be signed by its maker may be too restrictive.

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[59] See for example, Ibid, pp. 8-10; R.L. Carey, "Choosing How to Die: The Need for Reform of Organs Living Will Legislation" 23 Willamette Law Review, Winter 1987; J. MacAvrey-Snitzer, "Pregnancy Clauses in Living Will Statutes", 87 Columbia Law Rev., Oct. 1987; L.A. Mash, "Living Will Legislation in Colorado: An Analysis of the Colorado Medical Treatment Decision Act in Relation to Similar Developments in Other Jurisdictions", 64 Denver University Law Rev., Winter 1987; D.R. Jones, "Amendments to the Living Will Statute: Two Down and One to Go", 23 Georgia State Bar Journal; N. Blodgett, "New Living Wills: Changes in Statutes Sought", 72 M. Bar Association J., September 1986; T.J. Marzen, "The Uniform Rights of the Terminally Ill Act: A Critical Analysis", 1 Issues in Law and Medicine, May 1986; and Meyers, "The California Natural Death Act: A Critical Appraisal", California St. B.J., July/August, 1977.

[60] Baker, Supra, note 58, p. 9. See also, The Report of the Centre of Medical Law and Ethics, note 3, p.59.

[61] Ibid, p. 9.

[62] Meyers, Supra, note 60.

[63] Rozovsky, Supra, note 53.

Quadraplegics and other patients who have been deprived of the physical capacity to execute the document should not be denied its benefits.

These and other peculiarities of the California legislation are not fatal to the concept of legislation, and could no doubt be cured by amendment. A more general criticism of the *Natural Death Acts*, however, focuses on the fact that they establish a single, inflexible mechanism for giving legal effect to an advance directive. The California *Act* provides that:

> Nothing in this chapter shall impair or supersede any legal right or legal responsibility which any person may have to effect the withholding or withdrawal of life-sustaining procedures in any lawful manner.

But the scope of this provision is by no means clear. While it appears on its face to preserve a right to refuse medical treatment without meeting the formal requirements of the legislation, the more specific terms of the *Act* appear to conflict with this proposition. The *Act* expressly provides that an advance directive is legally-binding in the case of a "qualified patient"; that is, a patient who has met the formal and substantive requirements established by the *Act*. In any other case, the advance directive is merely "advisory". Moreover, the very fact that the legislation establishes a definitive procedure may discourage physicians from giving effect to manifestations of intention expressed in other forms. Thus, it would appear that any advance directive that does not meet the rather stringent requirements of the statute will be deprived of legal effect. Since advance directives may have been legal in at least some circumstances prior to adoption of the legislation, the legislation may have had the unexpected effect of placing some new limits on the right to refuse medical treatment.

This is perhaps a more serious objection to the legislation than it might appear at first blush. As noted above, existing living wills run the gamut from the very simple to the very complex. Some may conform with the requirements of the *Natural Death Acts*; many may not. It would be undesirable if a matter of mere form prevented some living wills which contain a clear expression of the patient's wishes from being given legal effect. Moreover, in many cases, a patient facing the final crisis of life will not obtain the kind of legal advice necessary to comply with the formalities of statutes following the California model. The Florida survey of the attitudes of elderly people towards advance directives indicated that many of them simply expect family members to be able to make decisions on their behalf in a critical situation, or expect their informally expressed wishes to be honoured. The researchers who conducted the survey concluded that:

> Despite urgings of legal and medical professions...that formal advance directives and formal proxy appointment ought to be used, caution is needed least the use of...less formal means and the elderly person's propensity to expect familial involvement...is under estimated.[64]

The experience with living wills legislation in the United States has been far from satisfactory. Nevertheless, the uncertain state of the law in the absence of such legislation creates an even less satisfactory state of affairs. The flaws in the California *Natural Death Act* are not so much an argument against legislation as a source of experience that can be drawn upon in drafting a second generation of living wills legislation.

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[64] Supra., note 49.

CHAPTER 4: THE ENDURING POWER OF ATTORNEY

An alternative to the living will is the appointment of a surrogate decision-maker for a patient who is no longer able to give or refuse consent to medical treatment. This approach has gained popularity with law makers in the United States as the problems inherent in *Natural Death Acts* on the California model have become apparent.[65] California once again led the way with legislation authorizing enduring powers of attorney[66] for health care purposes, and several other States have followed the example. The enduring power of attorney avoids the onerous time frames of the *Natural Death Acts*, and unlike them, can be made applicable to treatment decisions in non-terminal situations.

The inadequacies of the *Natural Death Acts* that are circumvented by enduring powers of attorney are not inherent in the concept of the living will. Nevertheless, there are some advantages in the use of surrogate decision-makers. If nothing else, enduring powers of attorney ought to be available as an alternative to the living will simply because some individuals will feel more comfortable delegating decision-making power to a trusted relative or friend, rather than attempting to formulate a binding direction to be applied in the future to circumstances which have not yet arisen. It would appear that some eighty or ninety percent of people who have contemplated the possibility of becoming incapable of making health care decisions think it appropriate that their closest relatives be enabled to act for them.[67] Moreover, most physicians and other health-care workers believe that the involvement of relatives in decision-making in terminal cases is desirable.

The enduring power of attorney may also avoid some of the drafting problems inherent in living wills. In particular, the problem of choosing between a form of directive that speaks in general terms, and a more detailed document that attempts to anticipate contingencies before they arise, largely dissappears if a substitute-decision maker is appointed to make specific decisions as need arises.

This is not to suggest, however, that the enduring power of attorney should be the only legally-recognized form of advance directive. There is a place for both the living will and the enduring power of attorney in a rational legislative scheme relating to advance directives. In practice, elements of both could usefully be combined in a single document. In fact, the typical enduring power of attorney authorized by American legislation incorporates both the living will and substitute-decision maker concepts:

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[65] Lorne Elkin Rozovsky and Fay Adrienne Rozovsky, The Canadian Law of Consent to Treatment, Toronto: Butterworths, 1989, p. 97.

[66] California Civil Code, Sections 2410-2443.

[67] Hugh M. Dallas, "All in the Family - Extended Autonomy Expectations in Surrogate Health Care Decision-making", Gerontologist, (1988) Vol. 20, (Supplement), pp. 46-51: Nancy Gibbs, "Love and Let Die", Time Magazine, March 19, 1990.

> A competent individual to designate another person to make health care choices for him. The substitute decision-maker would step in when the individual became incapable of participating in treatment decision-making. In some instances, the individual can give the person with the "durable" power of attorney instructions regarding potential health care choices. In other cases, it may be a matter of creating the "power of attorney" and leaving it up to the substitute decision-maker to make reasonable choices at the appropriate moment.[68]

The legal status of an enduring power of attorney or other attempt to appoint a surrogate decision-maker in Saskatchewan is more problematic than the status of the living will. As the review of the law in the last chapter indicated, there is no common law doctrine that would give legal status to a surrogate decision-maker.[69] Legislation will be required to give effect to appointment of surrogate decision-makers in Saskatchewan.

Nova Scotia adopted legislation in 1988.[70] Like the Saskatchewan legislation relating to powers of attorney, the *Nova Scotia Powers of Attorney Act* permits a competent adult to grant a power of attorney that remains in force even after the maker has become incompetent. Unlike the Saskatchewan legislation, the Nova Scotia *Act* extends the scope of powers of attorney. The grantor of the power may include a clause granting authority to make health care decisions on behalf of the grantor in the event that the grantor becomes unable to do so. Since the appointment of the surrogate takes a form similar to a traditional power of attorney, it must be in writing, and signed by the maker.

Although many of the problems inherent in the *Natural Death Act* are avoided by the Nova Scotia legislation, it has some shortcomings. In particular, because it must be signed, its benefits may not be available to stroke victims and quadraplegics. Nevertheless, as one commentator suggested:

> The Nova Scotia law is a positive step in the right direction. It offers many people a practical resolution to their fears regarding unwanted medical intervention should they become incapable of refusing such treatment.[71]

Like the California *Natural Death Act*, it provides a useful starting point for further consideration of appropriate law reform.

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[68] Ibid, p. 97.

[69] The Powers of Attorney Act, S.S. 1982-83, C. 20.1.

[70] Medical Consent Act, S.N.S. 1988, C. 14.

[71] Ibid, p. 98.

CHAPTER 5: RECOMMENDATIONS

1. The Need for Legislation

Even though the common appears to recognise advance health care directives withholding consent to treatment that prolongs life in a last illness, the discussion of the state of the law in this report suggests that enough uncertainty still exists to make clarification through legislation desirable. If the common law is to be extended to recognize appointment of a substitute-decision maker to act on behalf of a patient who becomes incompetent, legislation is almost certainly necessary. In the Commission's view, both forms of advance directive should be available to those who seek to ensure a death with dignity, and both should be given clear legal recognition.

In recommending legislation, the Commission agrees with the conclusion reached by a majority of law reform agencies that have studied the question.[72] There is not, however, universal acceptance of the need for legislation. The Law Reform Commission of Canada, after concluding that there is no substantial impediment in Canadian law to recognition of living wills, recommended no legislation.[73] The British Medical Association, unlike its Canadian counterpart, has also expressed opposition to legislation.[74] In part, the Association's position reflects a concern that legislation might lead to over-regulation of the doctor-patient relationship, jeopardizing good medical practice rather than encouraging it.

Experience under the California *Natural Death Act* and its imitators gives some substance to this concern. The Centre of Medical Law and Ethics report summarized the stifling effects of the *Natural Death Acts*:

> [I]t is already evident that the various State laws have had a significant effect on medical practice in the USA. It has been said that the doctor-patient relationship has been changed by the intense legislation of American medicine, piling external constraints in the form of law on the ethical framework operated by the profession.... Legal pressures may prompt physicians to ignore death as an ethical right....[75]

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[72] In addition to the Manitoba Law Reform Commission and the U.S. President's Commission, legislation has been recommended, and in some cases adopted, in several Australian jurisdictions. See The Law Reform Commission of West Australia, Report on Medical Treatment for the Dying, 1991.

[73] Euthanasia, Aiding Suicide and Cessation of Treatment, note 4, p. 69.

[74] See the Centre of Medical Law and Ethics report on living wills, note 3, p.3 for discussion of the British Medical Association's position.

[75] Ibid., p.50.

Similar critiques of the American approach have been expressed by Canadian commentators.[76] The problems inherent in the California legislation have been discussed above; in the Commission's view, it is not an appropriate model. By insisting on elaborate formalities and conditions precedent to legal recognition, it creates almost as much uncertainty as it alleviates.

In the Commission's view, the arguments in favour of legislation out-weigh the disadvantages. But the legislation should provide affirmative legal recognition of advance directives with a minimum of formalities and regulation. It should clarify the law and satisfy both physicians who may be called upon to honour directives, and members of the public who wish to make directives. The legislation should be no more than a framework which encourages good medical practice, and protects physicians and other health care providers who act on the clearly expressed wishes of a patient.

Such refinements in the California legislation as periodic renewal and cooling off periods before the directive takes effect should be avoided.[77] No mandatory form of directive should be mandated by the legislation.[78] In the Commission's view, these are matters best left to judgment of individuals making advance directives and their advisors.

Recommendation: Legislation should be adopted giving legal recognition to advance directives, including both living wills and nomination of substitute-decision makers. The legislation should impose a minimum of regulation and formal requirements.

2. When an Advance Directive Applies: Triggering Events

The purpose of an advance directive intended to permit its maker to die naturally is to withhold consent to medical treatment that is intended only to prolong life in what may be called a last illness. Advance directives, defined in this manner, do not include instructions regarding health care made in other circumstances. The Commission has concluded that legislation should apply only to advance directives taking effect in a last illness.[79]

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[76] A. Parsons, "Allocating health care resources: A moral dilemma", Canadian Medical Association Journal, 1985, vol. 132, p. 466. Concern was expressed to Commission in this regard by Dr. Harry Emson.

[77] See Above, p. 21.

[78] The Manitoba Law Reform Commission similarly rejects a mandatory form, but recommends that a model form might be included in regulations made under advance directives legislation. The Saskatchewan Commission is concerned that even a model promulgated by regulation may prove restrictive in practice: A reluctance to accept directives not following the official form could well develop. In any event, there is no longer any shortage of model directives. They are available through organizations such as Saskatchewan Death with Dignity, in lawyer's offices, and even in bookstores.

[79] In this respect, the Saskatchewan Commission differs from the point of view expressed by the Manitoba Commission. The Manitoba recommendations would recognise all advance health care directives, whether they relate to a last illness or not. On the other hand, the Manitoba recommendations do not purport to alter the common law in regard to the right to refuse treatment in cases not involving a last illness. This approach avoids some of the difficulty in defining "triggering events" discussed below, but introduces practical uncertainty about the scope of the legislation. Furthermore, it introduces greater complexity. For example, provisions relating to experimental treatment are required in the Manitoba recommendations, but are hardly necessary in a regime applicable only to a last illness.

RECOMMENDATIONS

The legislation should not apply, for example, to a Jehovah's Witness wallet card stipulating that no blood transfusion is to be given to the bearer. The common law may permit a person to refuse medical treatment in some life-threatening situations that would respond to treatment, though the limits of the right to do so have not been fully explored by the courts. Nothing in the legislation should limit any common law right to refuse treatment, but the legislation should not extend its specific protections beyond advance directives intended to take effect in a last illness. Neither more nor less is required to give expression to the emerging consensus favouring a right to die with dignity.

The restricted definition of advance directive proposed here makes it essential that the legislation clearly define the circumstances which will bring a directive into effect: the triggering events which will permit a physician to act on the directive.

The US *Natural Death Acts* stipulate that an advance directive takes effect only if the maker is suffering from a terminal illness. The notion of "last illness" contemplated here is broader than "terminal illness", particularly if, as appears to have been the case in the United States, "terminal illness" is given a narrow definition.[80] Neither AIDS nor Altzheimer's Disease are terminal diseases under a restricted definition of the term. Death in both cases usually results from secondary infection or other complication. Under the California legislation, an advance directive instructing that antibiotics be withheld from an AIDS patient in an advanced stage of the disease who has contacted pneumonia would probably not be valid. The pneumonia is treatable, and a "recovery" (even if it means no more than waiting for the next bout of pneumonia) is likely. The concern which has made the living will an attractive option for many people extends to treatment that maintains a life that is no longer meaningful to the suffering patient, whether the underlying condition will necessarily be fatal in short term or not. The AIDS or Alzheimer's patient who contracts pneumonia should be allowed to die under the terms of an advance directive.

Inevitably, any triggering event that extends beyond terminal conditions must focus on the patient's quality of life. Living wills in current use often stipulate that the document is to take effect when the patient will suffer a significant and permanent loss of physical or mental capacity. In *Let Me Decide*, Dr. David Molloy recommends a form of directive triggered by "irreversible illness", and notes that:

> Some people would not consider themselves debilitated if they were confined to a wheelchair or even bedridden. Others could not accept this loss of independence. ....Blindness would have made little difference to [Beethoven]....But a painter such as Picasso would dread blindness....It is not possible to say when illnesses are irreversible for everybody.[81]

The Centre of Medical Law and Ethics characterizes quality of life as "an elusive concept", but accepts that it is "essential in this process of assessment and decision-making".[82]

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[80] D.L. Redleaf et. al., "The California Natural Death Act: An empirical study of physicians' practices", Stanford Law Review, 1979, vol. 31, p. 913.

[81] Note 10, p. 17.

[82] Note 3, p. 11.

Attempts to define quality of life are probably futile, though attempts have been made to do so.[83] From a legislative point of view, however, the definitional problem is a restricted one. The function of a defined triggering event is to set an outer limit to prevent misuse of advance directives. Within the broad limits to be established by the legislation, it should be left to the maker of the directive to define the degree of permanent disability he or she regards as unacceptable, with as much particularity as he or she deems necessary. For this purpose, some imprecision of language is tolerable if physicians are protected when acting in good faith and with as much consultation with other care providers and the patient's family as circumstances permit.

Recommendation: An advance directive should be given recognition if it is intended to take effect when the maker is suffering from a condition that is terminal, or will result in a significantly diminished quality of life.

3. Capacity and Incapacity

An advance directive is usually made to provide instruction in regard to treatment in the event that its maker becomes unable to make decisions for himself or herself. Incapacity might, therefore, be stipulated as an additional triggering event necessary to bring a directive into effect. In the Commission's view, however, it is neither necessary nor desirable to include a reference to incapacity in advance directives legislation. There are at least two reasons for adopting this approach.

First, it would appear that at common law a competent patient has a right to refuse medical treatment in a last illness. Since the legislation is intended to clarify the law, it would be desirable to encompass the right of a competent patient to refuse treatment in it. If the definition of "Advance Directive" implied by the legislation includes a directive that can take effect even while the patient remains competent, any doubt about the state of the law in this regard will be removed.

Second, if incapacity is not a triggering event, it will not be necessary to make a finding of incapacity in order to determine whether an advance directive can be applied. Deciding whether a patient retains the ability to make a rational decision about treatment can be difficult in some cases. For example, a patient in considerable pain, or a patient who is only intermittently conscious, may be difficult to characterize as capacitated or incapacitated. Some doubt might also surround cases in which a decision to provide or withhold further treatment has to be made during surgery. For example, a patient may stipulate that if it is discovered during surgery that a cancer has spread widely, no attempt be made to remove the tumors. It is perhaps uncertain whether the patient can be regarded as incapacitated simply because he or she is unconcious during the surgery.[84] Problems such as these can be avoided if incapacity is not a triggering event necessary to bring an advance directive into effect.

A more difficult problem involves capacity to make the advance directive in the first place. Obviously, the ability to evaluate treatment options is the essential requisite of capacity to make a directive. For this purpose, the concept of capacity as ordinarily understood in law is

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[83] See Ibid., p.11 for a discussion. Denham, for example, stresses "health,... health perception, function and mental health...life satisfaction, life domain...and quality of the environment." See M. Denham, "Assessment of quality of life", Care of the long stay elderly patient, Kent, 1983, pp. 31-43.

[84] Thus whether a surgeon can take steps during surgery that have not been specifically authorized by the patient is uncertain. In Marshall v. Currey [1933] 3 D.L.R 260 (N.S.S.C.), the surgeon's decision to proceed was held to be non-tortious. On the other hand, in Murray v. McMurchy [1949] 2 D.L.R. 442 (B.C.S.C.,) it was held that in anything short of a case of requiring "immediate decision", the appropriate course of action would be to obtain consent from the patient to a second operation rather than proceeding further than authorized in the first.

satisfactory. But, although persons under the age of majority have capacity to consent to health care in some circumstances, the Commission has concluded that recognition should be given in the legislation only to directives made by adults.

Practical difficulty relates more to the determination of capacity than to definition of the term. The problem is particularly acute when only the observations of friends and family made some time before the validity of the agreement is tested can be relied upon to determine the capacity at the time the directive was made. In such cases, the physician can do no more than make reasonable inquiries and exercise common sense. In other cases, consultation with psychiatrists and social workers as well as family may be possible. It is essential in any event that a physician who acts reasonably be protected from liability. The Commission agrees with the Centre for Medical Law and Ethics that:

> Provided capacity is defined, the question whether the test is satisfied is a matter for clinical judgment. In the event of a dispute as to whether the person was competent to execute the document, it is suggested that it should be presumed that he was, i.e. the onus of proving that he was not should be on the person so claiming.[85]

Under some of the American *Natural Death Acts*, once the maker of an advance directive has become incapacitated, the directive can no longer be revoked. This is perhaps logical enough. It can be argued that a rational decision made by a competent individual to guide physicians when rationality has been lost should not be jeopardized by a change of heart after the ability to access options is gone. On the other hand, most people who contemplate making an advance directive would reject the notion that it might be enforced even against their protests. Few doctors would accept a regime which called upon them to withhold life-sustaining treatment from a patient who wants it, whether the patient is clearly capacitated or not. For that reason, the Commission has concluded that advance directives should be easily revoked, and that no test of capacity to make the decision to revoke be included in the legislation.

Recommendation: (1) An advance directive made by a mentally competent adult should be given recognition in the legislation.

(2) An advance directive should be revokable without formality, and without consideration of capacity.

4. Formalities

Because the term "living will" has come to be applied to advance directives, many of the models have adopted formalities similar to those required to establish the validity of testamentary

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[85] Note 3, p. 56.

documents. Substantial formal requirements are also stipulated by the American *Natural Death Acts*. At common law, however, no particular formalities are required to manifest a refusal to consent to health care. Excessive formal requirements have been one of the reasons for the limited success of the *Natural Death Acts*. In principle, any clear manifestation of intent should be recognized. It would be unfortunate if a clear expression of a patient's wishes failed only because of a lapse in formalities. Moreover, as the Centre of Medical Law and Ethics observed "[I]t is important to notice that a large proportion of people wishing to have recourse to [living wills]...are elderly. Thus, the formalities involved would arguably have to be the bare minimum to establish the document's validity."[86]

A signed directive should be accepted without further formality. Although witnessing may be an aide to establishing validity, other evidence satisfying the physician that the document represents the patient's wishes should also be accepted. In this, as in other matters relating to the effectiveness of a directive, a physician acting reasonably and in good faith should be protected.

Even absence of the minimal formalities outlined above should not be fatal. Some patients, due to illness or injury may be physically unable to sign. In such cases, the formality of a signature should be dispensed with. In a few cases, even the requirement of writing may be inappropriate. Consider a crisis situation in which a patient makes wishes known to the attending physician just before loosing consciousness. A rejection of treatment would likely be valid at common law in such a circumstance, and direct communication with the physician removes any doubt that the communication represents the patient's wishes.

Recommendation: Advance directives should be subject to minimal formal requirements. While a signed directive in writing should ordinarily be required, provision should be made for exceptional circumstances where even these formalities cannot be met, and there is other evidence of validity.

5. Content of Advance Directives

It was argued above that no official form of directive should be stipulated. Similarly, only minimal regulation of the content of directives should be included in the legislation. The legislation should recognise both living wills and appointment of substitute-decision makers, or any combination of the two. Both directives drafted in general terms, and those including stipulations in respect of specific treatments should be acceptable. A broadly-worded directive will give the attending physician more *de facto* discretion in determining appropriate treatment, but whether that is acceptable should be a matter left to the maker of the document.

Specific stipulations as to content of the sort found in the *Natural Death Acts* should be avoided. For example, many of the American *Acts* provide that a directive ceases to have effect during pregnancy. In Canada, the recent *Morgenthaler* decision may be authority for the

[86] Ibid., p. 56.

proposition that a woman cannot be forced to carry a child to term if the cost to her is the pain and suffering of a prolonged terminal illness. Certainly, many women would choose to carry the child to term even under such circumstances. It would be open to a woman, of course, to include a clause in her living will suspending it in the event of pregnancy. Even if no such clause is present, it may be open to an attending physician, after consulting with family and friends, to conclude that the directive no longer represents the patient's wishes. It is unacceptable, however, to presume that a woman would choose to continue her life in such circumstances.

Recommendation: The legislation should make no substantive requirements in respect of the content of advance directives.

6. Enforcement of Rights

The principal goal of advance directives legislation should be to provide a mechanism that removes doubt about the validity of directives, and protects health care workers who carry out a patient's wishes.

At one time, resistance in the medical profession to the notion that a patient has a right to reject prolongation of a final illness was a significant impediment to recognition of living wills. But attitudes have changed in the profession. While some commentators have suggested that legislation should require physicians to carry out valid directives, such a provision is now neither necessary nor desirable. Decisions such as *Mallet v. Shulman* have made it reasonably clear that a physician who ignores a patient's directive will be liable in tort. The only basis for refusing to act on a directive (or finding a physician who will if the physician's personal ethics preclude him or her from doing so) is doubt that the directive is a true reflection of the patient's wishes. Legislation setting minimum formal requirements and procedures for assessing the validity of directives can be expected to operate in tandem with the common law: A directive conforming to the *Act* could be ignored only at peril of litigation. Creating a new, statutory, sanction would add little to the effectiveness of the law, and might contribute to scepticism about the legislation in the medical profession.

Similarly, a minimalist approach to regulation of advance directives suggests that legislation should not include a statutory mechanism for review by the courts. A dispute about the validity or interpretation of a directive could be litigated in the absence of a statutory provision by making application for a declaratory judgment under the Rules of Court, and as noted above, refusal to act on a directive could found a tort action. Unless experience proves otherwise, their appears to be no reason to complicate matters by legislating new procedures.

The most important contribution legislation can make to the development of advance health care direr4ives law is to provide greater clarity for health care workers. In the Commission's view, directives will be accepted by the medical profession if the legislation clearly provides protection from liability for physicians and other health care workers who carry out directives in good faith and with reasonable judgment.

Recommendation: Physicians and other health care workers acting under a physician's direction should not be liable for implementing the terms of an advance directive if they act reasonably and in good faith.

APPENDIX

A Proposed Act Respecting Advance Health Care Directives

1. This Act may be cited as the Advance Health Care Directives Act.

2. Any person who is of the full age of majority and who is mentally competent may make an advance health care directive as provided in this Act for the purpose of giving direction to physicians and others when the person is suffering from a condition, illness, or injury that is terminal, or which will result in a significantly diminished life expectancy, physical or mental capacity, or quality of life.

3. (1) A directive made for the purposes mentioned in Section 2 may

(a) stipulate medical treatment, procedures, or medication that the person who made the directive authorizes or refuses to consent to, or directs to be discontinued, in the circumstances set out in the directive;

(b) stipulate circumstances in which the person who made the directive shall be permitted to die a natural death, receiving only palliative care intended to reduce pain and suffering;

(c) nominate a person or persons to make decisions about medical treatment on behalf of the person who made the directive; or

(d) make any other direction concerning the care or medical treatment of the person who made the directive.

(2) Unless a directive expressly provides otherwise, where the directive instructs that medical treatment intended only to prolong life shall not be provided, the physician in attendance may administer medication to reduce pain and suffering, even if the effect of the medication may shorten the life of the person who made the directive.

4. (1) A physician, or any person acting under the direction of the physician, who, in good faith, acts in accordance with a directive made for the purposes mentioned in Section 2, is not liable in law for so doing if

(a) (i) The directive is in writing, and signed, and the physician is satisfied that the directive expresses the intention of the person to whom it applies; or

(ii) The directive is in writing and the person who made the directive was unable, due to illness or injury, to sign it, but after consultation with a person present when the directive was made, the physician is satisfied that it truly reflects the wishes of the person who made it; or

(iii) The directive was given verbally to the physician by its maker under circumstances which made compliance with clause (i) or (ii) impracticable;

(b) The physician, after consultation where practicable, is satisfied that the person who made the directive was of full age and mentally competent when the directive was made; and

(c) The physician, after the patient has been examined by another physician, where practicable, who concurs with his opinion, is satisfied that circumstances exist which make the directive applicable.

(2) A physician is entitled to presume, in the absence of evidence to the contrary, that a written directive was made by the person who purported to sign it, and that it has not been repudiated.

5. A directive shall have no effect if it has been repudiated, orally or in writing, by the person who made it, at any time after it was made.

6. (1) Nothing in this Act shall give validity to a direction that would be of no effect at common law for the reason that it

(a) authorizes the administration of any substance or performance of any procedure for the purpose of terminating the life of a person; or

(b) would likely result, if acted upon, in the death of a person who would, if treated, reasonably be expected to recover without substantial physical or mental impairment.

(2) Nothing in this Act derogates from any right recognized at common law to refuse consent to medical treatment.